Dr. Tai Chung

PATIENT INFORMATION SHEET

Referring Physician: Julio Rios

[redacted] Social Security Number

Date of Injury or Illness: 2/23/06

Cedric First Name | R MI | Pugh Last Name | Title

[redacted] Date of Birth | 30 Current Age | Male ✓ | Female

Marital Status: ✓ Married __ Single __ Divorced __ Widowed Patient's Occupation:

Elmore Correctional Center Address | City | AL State | 36025 Zip Code

Home Telephone Number | Work Telephone Number | Cellular Telephone Number

Patient's Employer | Employers Address, City, State and Zip Code

Is your visit related to a workman's comp injury? If so, please list w/c Ins.

Workman's Comp Insurance adjuster's name:

Indicate who we may speak with or leave a message regarding your health information Staton Health Care Unit

Emergency Contact Name(s)

Relationship | Home Telephone Number | Work Telephone Number

Present Complaint | Chronic Illness:

Drug allergies | Medications currently taking: (1)

(2) (3) (4) (5)

PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONIST
RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES.

I hereby authorize Dr. Tai Chung to release any information necessary to process any insurance claim acquired in the course of my examination or treatment to allow a photocopy of my signature to be used to process my insurance claim. I state, direct, and authorize my carrier to issue payment check(s) directly to Dr. Tai Chung, for any insurance benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by my carrier. Regardless of insurance benefits, if any, I understand that I am fully responsible for any and all fees incurred and I agree the above is a legal and lawful debt. If it becomes necessary to forward this account to collections, I agree to be responsible for any/all collection costs, attorney fees and/or court costs. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state. I realize that in extraordinary circumstances, some insurance companies will not pay for certain procedures (i.e. MRI's or surgeries). I understand that my insurance is filed as a courtesy and I am responsible for the bill.

Cedric Pugh
Patient/Responsible Party Signature | Date

Payment of co-payment is expected at the time of service. Check ____ [redacted] ____ Cash ____

Please send this form wi[illegible] must be Complete and Legible. You must type or p[illegible]
Authorization Letter to the service provider at th[illegible] this Appointment

Site Name & Number: 843 - STATON
Site Phone #: 334-567-1548
Site Fax #: 334-567-7167

DEMOGRAPHICS

Patient Name: (Last, First,) Pugh, Cedric
Alias: (Last, First,)
Inmate #: 182373
SS Number: [redacted]
Date: (mm/dd/yy) 02.24.06
Date of Birth: (mm/dd/yy) [redacted]
PHS Custody Date: (mm/dd/yy) 2.6.97
Potential Release Date: (mm/dd/yy) 8.1.2007

Will there be a charge? ☑ Yes ☐ No
Sex ☑ Male ☐ Female
Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☑ NP, PA ☐ Dental
J. M. Peasant, Sr., M.D. [signature]
Facility Medical Director Signature and Date:
☐ Service meets criteria for "approval via protocol"

Place a check mark (√) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)
☐ Routine ☐ Urgent
Estimated Date of Service (mm/dd/yy): 1 1
(This starts the approval window for the "open authorization period")
Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy
Number of Visits/Treatments: 1 ☐ Other:
Specialist referred to: Dr Chang
Type of Consultation, Treatment, Procedure or Surgery: Evaluate i tx
Diagnosis: Packed Traumatic amputation (R) 3rd dig. PIP
ICD-9 code:
You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.
☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:
2/23/06 → Got finger caught in mixer & ½ of finger amputated (R) 3rd digit. Sent to BMCS for tx; needs to see ortho for tx

Results of a complaint directed physical examination:
(R) 3rd finger wrapped & painful dsg. DSG not removed @ this time. Pain to ER visit ½ of finger c traumatic amputation
FAXED 5/1/06

Previous treatment and response (including medications):
Appt scheduled i Dr. Chang on 2/27/06 @ 1415 ① URGENT
TAKE XRAYS to Appt
For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:
☐ Offsite Service Recommended but Authorized
☐ Alternative Treatment Plan (explain here):
☐ More Information Requested: (See Attached)
☐ Resubmitted with requested information.
Date resubmitted: 1 1
Regional Medical Director Signature, printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.
Cert Type: Med Class:
CPT code:
UR Auth #:

05a - UM Referral review form
F. Ellis RN

Dr. Tai Chung

PATIENT INFORMATION SHEET

[redacted] Social Security Number

Referring Physician: Julio Rios

Date of Injury or Illness: 2/23/06

Cedric First Name | R MI | Pugh Last Name | Title

[redacted] Date of Birth | 30 Current Age

Male ✓ Female ____

Marital Status: ✓ Married __ Single __ Divorced __ Widowed Patient's Occupation: ____

Elmore Correctional Center Address | City | AL State | 36025 Zip Code

Home Telephone Number | Work Telephone Number | Cellular Telephone Number

Patient's Employer | Employers Address, City, State and Zip Code

Is your visit related to a workman's comp injury? If so, please list w/c ins. ____

Workman's Comp insurance adjuster's name: ____

Indicate who we may speak with or leave a message regarding your health information Stanton Health Care Unit

Emergency Contact Name(s)

Relationship | Home Telephone Number | Work Telephone Number

Present Complaint: | Chronic Illness:

Drug allergies ____ Medications currently taking: (1) ____

(2) ____ (3) ____ (4) ____ (5) ____

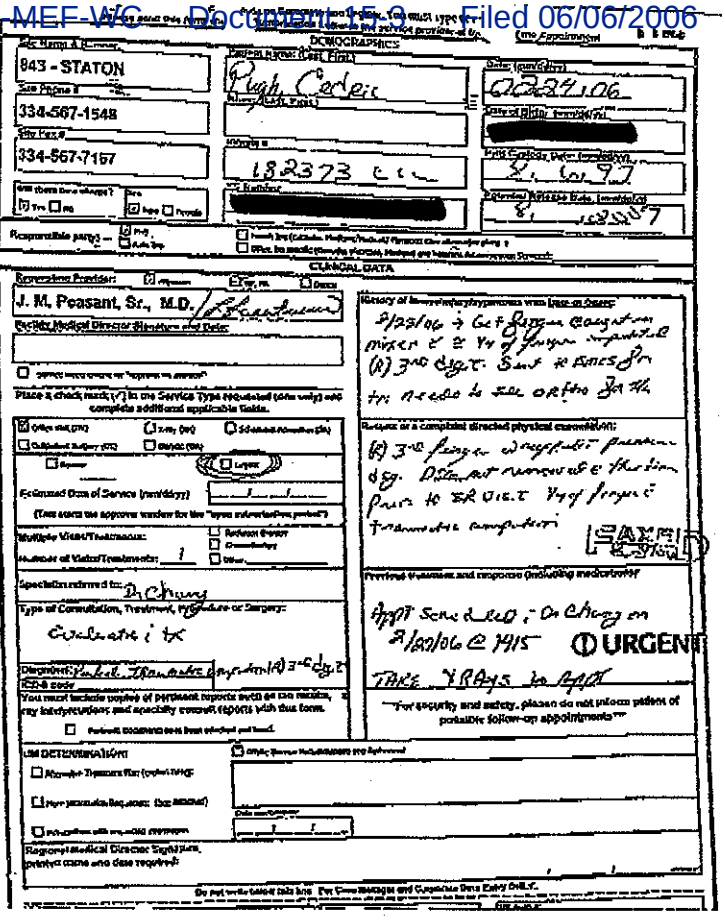
PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONIST

RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES.

I hereby authorize Dr. Tai Chung to release any information necessary to process any insurance claim acquired in the course of my examination or treatment to allow a photocopy of my signature to be used to process my insurance claim. I claim, direct, and authorize my carrier to issue payment check(s) directly to Dr. Tai Chung, for any insurance benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by my carrier. Regardless of insurance benefits if any, I understand that I am fully responsible for any and all fees incurred and I agree the above is a legal and lawful debt. If it becomes necessary to forward this account to collections, I agree to be responsible for any/all collection costs, attorney fees and/or court costs. I waive now and forever my right of Exemption under the laws of the constitution of the State of Alabama and any other state. I realize that in extraordinary circumstances, some insurance companies will not pay for certain procedures (i.e. MRI's or CT scans). I understand that my insurance is filed as a courtesy and I am responsible for the bill.

✓ Cedric Pugh
Patient/Responsible Party Signature | Date

Payment of co-payment is expected at the time of service. Check ____ [redacted] ____ Cash ____



DEMOGRAPHICS

843 - STATON

334-567-1548

334-567-7157

Pugh, Cedric

182373

2/27/06

CLINICAL DATA

J. M. Peasant, Sr., M.D.

2/27/06 → Cut finger caught in mixer c 2 Yrs of finger impaired
(R) 3rd dgt: Saw it Rings Fx
tx: needs to see ortho for FU

(R) 3rd finger w/ partial amputation of dig. Distal aspect involving the skin
Pain to ER visit Yrs of finger
Treatment completed

FAXED

Appt scheduled: Dr Chang on 2/28/06 @ 1415 ① URGENT

TAKE XRAYS to appt

"For security and safety, please do not inform patient of possible follow-on appointments"

CEDRICK PUGH OFFICE VISIT FEBRUARY 27, 2006

CHIEF COMPLAINT: The patient is a 30 year-old right hand dominant gentleman referred from the correctional facility with complaint of right middle finger pain after he had it caught in a meat grinder about four days ago. He was seen at Baptist South. Apparently his finger was cleaned and dressed. He is here for further care. He had no previous injury to this area.

MEDICAL HISTORY: Is not remarkable for any serious illness.

MEDICATIONS: None.

ALLERGIES: None.

EXAMINATION: There has been a partial amputation of the pulp of the right middle finger. This is on the ulnar side. It involves about half of the pulp of the finger. He can wiggle the tip of the finger. There is no gross dirt contamination. X-rays showed that a bit of the tip of the distal phalanx has been amputated.

IMPRESSION: Amputation of left middle finger with exposed wound.

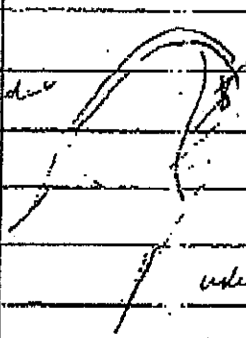
PLAN: To the OR for debridement and repair and most likely skin graft from the groin to the finger. Risks of surgery include anesthesia, infection, neurovascular and tendon damage, skin graft not taking requiring a re-do, incomplete resolution of symptoms and return of function in the hand. He understands and wishes to proceed with surgery.

Tai Q. Chang, M.D.

TQC/rpk

PHS
PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: Cedric Hugh[illegible] D.O.B.:
2/27/06	30 y/o @ [illegible] @ [illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible] pulp [illegible] [illegible] [illegible]
	
	[illegible]
	[illegible]
	[illegible]
	[illegible] (signature)

3111 (5/85)

Complete Both Sides Before Using Another Sheet

BAPTIST MEDICAL CENTER EAST
400 Taylor Road
P.O. Box 17720
Montgomery, Alabama 36193-4201

PATIENT: PUGH, CEDRIC	ROOM #:
MR #:	PATIENT #:
PHYSICIAN: TAI Q. CHUNG, M.D.	ADM. DATE:

PATIENT VERIFICATION DATA:
PUGH, CEDRIC

DATE OF PROCEDURE:

ADMISSION DIAGNOSIS: Partial amputation of right middle finger.

HISTORY OF PRESENT ILLNESS: The patient is a 30-year-old right hand dominant gentleman who had the tip of his right middle finger amputated by a meat grinder on 2/23/06. This was dressed in the ER. He is now admitted for debridement and repair of the wound with most likely skin grafting from the groin. He had no previous injury to this area.

PAST MEDICAL HISTORY: Not remarkable for any serious medical illness.

MEDICINES: None.

ALLERGIES: None.

PHYSICAL EXAMINATION
HEAD & NECK: Normocephalic, atraumatic. EOMI. PERRL.
LUNGS: Clear to auscultation.
HEART: S1, S2.
ABDOMEN: Bowel sounds normal, soft, nontender.
NEUROLOGIC: CNS II-XII within normal limits. Motor and sensory within normal limits.
MUSCULOSKELETAL: The ulnar aspect of the pulp of the distal phalanx has been amputated. There is no gross dirt contamination. The nail plate is still present.

IMPRESSION: Oblique amputation of the tip of the right middle finger.

PLAN: To debride and repair the wound with possible skin graft from the groin. Risks of surgery have been discussed with him including anesthesia, infection, lack of taking of the skin graft, incomplete resolution of symptoms and return of function in the hand. He understands and wishes to proceed with surgery.

TAI Q. CHUNG, M.D.

TQC/jcw
D: 03/01/2006
T: 03/01/2006

TBA

CEREDORES
BAPTIST HEALTH
2015
PUGH, CEDRIC
E0606100177
EC00279152

DATE OF SURGERY:
03/02/2006

PREOPERATIVE DIAGNOSIS:
Amputation of right middle finger tip.

POSTOPERATIVE DIAGNOSIS:
Amputation of right middle finger tip.

OPERATIVE PROCEDURE:
Revision of amputation of right middle finger tip.

SURGEON:
TAT Q. CHUNG, MD

ASSISTANT AND/OR CO-SURGEON:

ANESTHESIA:
General.

ESTIMATED BLOOD LOSS:
Less than 1 cc.

INDICATIONS FOR SURGERY:
The patient is a 30-year-old gentleman who had an amputation of the tip of his right middle finger about a week ago in a meat grinder.

FINDINGS AT SURGERY:
There is no gross dirt contamination. There is an oblique amputation of the outer aspect of the pulp of the distal phalanx. There are some bony fragments in the wound.

PROCEDURE:
With the patient under adequate general anesthesia, the right arm was prepped with Betadine and draped free in the usual fashion. The arm tourniquet was inflated to 250 mmHg. The injured area was irrigated copiously. The anatomy was explored. Multiple bone chips were removed. The ulnar neurovascular bundle was dissected and the digital nerve was traced proximally to be taken off proximal to the wound. Hemostasis was obtained. The wound was then closed carefully with 4-0 nylon sutures. A digital block was done with 10 cc of 0.25% plain Marcaine. A sterile dressing was applied. Tourniquet was deflated.

(CONTINUED)

CEDRICK PUGH **OFFICE VISIT** **FEBRUARY 27, 2006**

CHIEF COMPLAINT: The patient is a 30 year-old right hand dominant gentleman referred from the correctional facility with complaint of right middle finger pain after he had it caught in a meat grinder about four days ago. He was seen at Baptist South. Apparently his finger was cleaned and dressed. He is here for further care. He had no previous injury to this area.

MEDICAL HISTORY: Is not remarkable for any serious illness.

MEDICATIONS: None.

ALLERGIES: None.

EXAMINATION: There has been a partial amputation of the pulp of the right middle finger. This is on the ulnar side. It involves about half of the pulp of the finger. He can wiggle the tip of the finger. There is no gross dirt contamination. X-rays showed that a bit of the tip of the distal phalanx has been amputated.

IMPRESSION: Amputation of left middle finger with exposed wound.

PLAN: To the OR for debridement and repair and most likely skin graft from the groin to the finger. Risks of surgery include anesthesia, infection, neurovascular and tendon damage, skin graft not taking requiring a re-do, incomplete resolution of symptoms and return of function in the hand. He understands and wishes to proceed with surgery.

Tai Q. Chung, M.D.

TQC/rpk

The patient was then awakened and returned to the recovery room in stable condition.

TAI Q. CHUNG, MD

DICTATED BY: TAI Q. CHUNG, MD

D:0126:US093 JOB:13668 SCR:2254270 000279152 D:03/03/2006 07:06
T:03/04/2006 09:48 Scribes (USA) Inc.

D: 03/03/2006
T: 03/04/2006

Authenticated by TAI Q. CHUNG, MD On 3/30/06 7:40:24 AM

PRINTED BY: D12473 DATE 5/1/2006

Patient Name:	Pugh Cedric	**Inmate Number:**	ECC 182373
Service Authorized:	Office visit		
Responsible Facility:	Staton	**Contact Name:**	Michelle Pope
Authorization Number:		**Telephone Number:**	(334) 285-5971

Note to Provider of Services:

- **Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.**
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

Please send this form + Authorization Letter to the service provider at t. of the Appointment

DEMOGRAPHICS

Site Name & Number: 843 - STATON

Patient Name: (Last, First) Pugh, Cedric

Date: (mm/dd/yy) 3/02/06

Site Phone #: 334-567-1548

Alias: (Last, First)

Date of Birth: (mm/dd/yy) [redacted]

Site Fax #: 334-567-7167

Inmate #: 182373

PHS Custody Date: (mm/dd/yy) 08/06/97

Will there be a charge? ☑ Yes ☐ No

Sex ☑ Male ☐ Female

SS Number [redacted]

Potential Release Date: (mm/dd/yy) 08/__/07

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

J. M. Peasant, Sr., M.D.

Facility Medical Director Signature and Date:

J M Peasant Sr 3/2/06

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: 1 ☐ Other:

Specialist referred to: Dr Chung orthopedist

Type of Consultation, Treatment, Procedure or Surgery:

FOV (R) middle finger debridement

Diagnosis: (R) middle finger fx [illegible]

ICD-9 code:

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☑ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

S/P middle finger debridement today

Results of a complaint directed physical examination:

finger c pressure dressing

Previous treatment and response (including medications):

FOV needed in 2WK (approx 3/16/06))

For security and safety, please do not inform patient of possible follow-up appointments

FOV copy of Dr Chung note dated 3/2/06

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

Date resubmitted: __/__/__

☐ Resubmitted with requested information.

Regional Medical Director Signature, printed name and date required: __/__/__ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type: Med Class: CPT code: UR Auth #:

OSa – UM Referral Evaluation

FAXED 3/10/06 KK

A. Thompkins 3/10/06

Rush, Cedric AIS 182315

Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

Clinical Summary or Attached Report

Has pain complaint @ middle finger
Eye pain Chronic
Rx Ranitidine - Check annual eye Exam
Return in 3 weeks

*** For security and safety, please do not inform patient of possible follow-up appointments. ***

Signature of Consulting Physician: _____ Date _____ Time _____

Reviewed and Signed By Medical Director _____ Date _____ Time _____

05/20/2004

CEDRIC PUGH **OFFICE VISIT** **MARCH 13, 2006**

CHIEF COMPLAINT: This is follow-up of repair of partial amputation of the right ring finger. No complaint.

EXAMINATION: Wound is clean.

PLAN: Remove sutures. Redress the wound. Keep it clean. Exercises to regain motion. See me in three weeks for follow-up.

Tai Q. Chung, M.D.

TQC/rpk

Augm

Date	Time	ROUTINE PRE OPERATIVE ORDERS DR. _____
		G. _____ UA: _____ Diabetic _____ Renal glycosuria _____ Dehydration _____ Stress incontinence _____ Fever _____ Dysuria _____ Abdominal & pelvic pain _____ Long term use medication H. ADDITIONAL LAB TESTS: _____ _____
		3. EKG: _____ MVP/murmer or other valve disorder _____ Chest pain discomfort pressure _____ Hypertensive disease _____ Pulmonary congestion & hypostasis (CHF) _____ Electrolyte/fluid abnormality _____ Tachycardia/palpitation _____ Ischemic heart disease (hx MI) _____ Dizziness _____ Other
		4. CHEST XRAY: _____ Existing pulmonary disease (asthma COPD etc) Specify _____ _____ Existing cardiac disease (hypertension CHF etc) _____ Internal Injury _____ Fever _____ Cough _____ Disorders of bone & cartilage (arthritis) _____ Other
		5. _____ Antibiotic: _____
		6. _____ NPO after midnight
		7. _____ ☐ TED or ☐ SCD hose prior to surgery
		8. _____ Other Orders _____
		9. Anesthesia Consult ☐ Yes ☐ No
		Page 2 of 2
		Physician Signature:

Form #PH 35020 Revised 06/25/04

BAPTIST MEDICAL CENTER EAST
400 Taylor Rd.
Montgomery, AL 36117
(334) 277-8330

Name: PUGH, CEDRIC

MR#: E000279152
Sex: Male
DOB: [redacted]
Q. MD

Account: E0606100177
Admit: 3/2/06
Room/Bed:

Admit Type: Outpatient Surgery
Discharge Date:
Age: 30 years
SS Number: [redacted]
Admitting Physician: Chung, Tia

Ordering Physician: N/A

Hematology

Routine Hematology

COLLECTION DATE:	3/2/06		
COLLECTION TIME:	10:23:00 AM		
		REF RANGE	UNITS
WBC	5.9	[4.3-10.3]	X10-3/cL
RBC	5.09	[4.69-6.13]	X10-6/uL
Hemoglobin	14.4	[13.0-17.5]	gm/dl
Hematocrit	43.4	[40.0-51.0]	%
MCV	85	[80-100]	FL
MCH	28	[25-31]	PG
MCHC	33	[32-35]	gm/dl
Platelet Count	229	[150-400]	X10-3/uL
RDW	12.4	[11.5-14.5]	%

Automated Differential

COLLECTION DATE:	3/2/06		
COLLECTION TIME:	10:23:00 AM		
		REF RANGE	UNITS
Neutro Auto	49	[30-75]	%
Lymph Auto	41	[20-53]	%
Mono Auto	10	[0-12]	%
Eos Auto	1	[0-8]	%
Baso/Bas Auto	0	[0-2]	%
Neutro Abs	2.9	[1.4-6.5]	#
Lymph Abs	2.4	[1.0-4.8]	#
Mono Abs	0.6	[0.1-0.8]	#

BAPTIST MEDICAL CENTER EAST
400 Taylor Rd.
Montgomery, AL 36117
(334) 277-8330

Account: E0606100177

Name: PUGH, CEDRIC

Eos Abs	0.0	[0.0-0.7]	#
Basophil Abs	0.0	[0.0-0.2]	#

MR#:
E0606100177
Printed:
Name: PUGH, CEDRIC

E000279152 Room/Bed:

03/02/06 2:11 PM

Account:

Sex: Male DOB: [redacted]

BAPTIST MEDICAL CENTER EAST
400 Taylor Rd.
Montgomery, AL 36117
(334) 277-8330

Name: PUGH, CEDRIC

Account:E0606100177

Eos Abs	0.0	[redacted]	[redacted]
Basophil Abs	0.0	[redacted]	[redacted]

MR#:
E0606100177
Printed:
Name: PUGH, CEDRIC

E000279152 Room/Bed:

03/02/06 4:06 PM

Account:

Sex: Male DOB: [redacted]